

Women vs. Cancer

ERIN ANDREWS

The acclaimed sportscaster shares how she used a cervical cancer diagnosis as an opportunity to start honest conversations

Read more on Page 14

04

"At 21, cancer was the last thing I ever expected to hear."

Caroline McNally, B.S.N., RN, Oncology Nurse Navigator, Ovarian Cancer Survivor

10

"We've made significant advances in treating metastatic cancer, but ultimately, we want to prevent cancer whenever possible."

Matthew A. Powell, M.D., President, Society of Gynecologic Oncology



Why Now Is the Time to Raise Awareness of Women's Cancers

Cancer prevention starts with awareness. Simple health questions and conversations can open the door to detection and lifesaving prevention.



I thought it was nothing." I have heard those five words more times than I can count.

This year, cancer will change the lives of more than 1 million women in the United States. Breast, lung, colorectal, gynecologic, and other cancers are very different diseases. But one pattern turns up again and again: a woman who noticed something and was told — or told herself — that it was nothing.

As a gynecologic oncologist, I see firsthand why awareness matters. Each September, Gynecologic Cancer Awareness Month calls attention to a group of cancers that too often go unspoken: ovarian, uterine, cervical, vulvar, vaginal, and several less common ones. More than 115,000 women in the United States are diagnosed with a gynecologic cancer each year.

The earlier, the better

That number is rising, and the picture is changing. Some of these cancers are increasingly diagnosed in younger women, and uterine cancer is now the fastest-growing gynecologic cancer in this country. Behind each diagnosis is a person, a family, and a story that changes in a single appointment.

The women who say those five words to me are not careless. They noticed bleeding that didn't fit the usual rhythm, bloating that didn't pass, pelvic pressure, or fatigue and decided it wasn't worth mentioning, because the symptoms were subtle, life was full, or it was difficult to talk about. And sometimes they did speak up — and were told it was nothing. That delay has a cost. These cancers are far more treatable when they are found early.

While the urgency is real, so is our

progress. Research is creating new opportunities for prevention and treatment. Understanding the role of the fallopian tube in ovarian cancer has opened the door to removing the tubes to reduce cancer risk without affecting hormonal status. Advances in genetic testing can identify inherited risk before cancer develops, connecting family histories across breast, ovarian, and other cancers, and allowing for enhanced screening and prevention. Routine Pap and HPV testing can detect cervical cancer and precancerous changes early, while HPV vaccination can prevent most cervical cancers.

#AskHer

For women diagnosed with cancer, minimally invasive and technology-enhanced surgeries are available for many, along with treatments that harness

the body's immune response or target specific features of a patient's tumor. But these advances only reach the women who walk through the door — and who are heard when they do.

Each of these cancers has its own risk factors, treatments, and symptoms — symptoms that are easy to explain away. Knowing what is normal for your body and insisting on an answer when something isn't is one of the most powerful things you can do.

So ask. Ask your mother and your sisters what runs in your family. Ask your doctor what your symptoms could mean, and ask again if the answer doesn't fit. Ask someone else if you need to. And if you are a spouse, a son, a friend — ask her. Through our #AskHer initiative, the Foundation for Women's Cancer (FWC) works to make those questions ordinary rather than awkward.

Breaking the silence

Conversations about women's health are too often treated as uncomfortable or even taboo. Every cancer in these pages deserves the same visibility and public dialogue as any other disease. That is the work of the Foundation: trusted, evidence-based education and research that improves prevention, early detection, treatment, and survivorship.

Awareness is more than a month on the calendar. It is what happens when a woman decides that the thing she has been ignoring is worth mentioning and when the people around her make it easy to say out loud. I know that by working together, we can hear "I thought it was nothing" far less often.



WRITTEN BY
Ginger J. Gardner, M.D., FACOG
Chair, Foundation for Women's Cancer (FWC); Gynecologic Oncologist, Memorial Sloan Kettering Cancer Center

Cancer: Before and Beyond Diagnosis

Jenica Patterson, Ph.D., senior director of the Milken Institute's Women's Health Network, details a cross-sector approach to cancer care that changes the course of women's health, from preventative strategies to survivorship realities.

Why is it important to think about women's cancer across the entire life course, rather than focusing only on diagnosis or treatment?

I think cancer is really talked about a lot as if it begins at diagnosis. But for women, there are so many other areas you have to take into consideration, like cancer risk, detection, treatment decisions, survivorship. These are all shaped by experiences that accumulate across the life course.

You need to look upstream and downstream. Upstream means prevention, screening, education, risk assessment, reproductive health, family history — really before a woman even enters an oncology clinic. Downstream is survivorship. Treatment ending doesn't mean cancer ends.

Survivorship includes long-term side effects, fertility concerns, bone and cardiovascular health, mental health, caregiving, and quality of life.

Many people think of cancer as a single moment — a diagnosis. How do experiences throughout a woman's life influence cancer risk, prevention, and outcomes?

One of the clearest examples is breast cancer screening. Within our Network, we released a mammography report looking at where screening capacity exists across the United States and where it doesn't relative to population need. One of the biggest findings was that 30% of counties in the United States do not have a mammography machine.

Even access to a machine can determine whether a woman receives an early diagnosis. If she can't get to a screening facility,

can't take time off work or can't find childcare or transportation, those become barriers before cancer is ever diagnosed.

Despite advancements in research and treatment, where do you see the greatest opportunity to improve outcomes for women facing cancer today?

We have extraordinary advances in imaging, genetics, treatment, and survivorship, but women still don't benefit from them equitably or consistently. Innovation alone isn't enough. If women can't access it because of geography, logistics, or financial barriers, we won't realize its full impact.



We need a systems-level approach to women's cancer care. We can't focus solely on diagnosis or treatment if we want the best outcomes for women.

Within the Women's Health Network Women, Cancer, and Access Working Group, we're identifying tools that already exist — screening opportunities, genetic testing, risk stratification, patient navigation — and looking at how they can be embedded into routine care.



Jenica Patterson, Ph.D. | Photo courtesy of Milken Institute

How can healthcare systems better address disparities in access, diagnosis, treatment, and survivorship?

The first step is recognizing that disparities emerge long before treatment begins. The mammography report showed how a woman's experience can be shaped by where she lives, her insurance coverage, transportation, caregiving responsibilities, and whether services even exist in her community. The challenges are rooted in infrastructure, geography, and healthcare system design.

A missed screening can lead to a delayed diagnosis. That delayed diagnosis can limit treatment, and a lack of navigation support can make it harder to complete treatment. It's a domino effect. The framework we're developing is designed to help health systems evaluate the entire cancer journey, identify where barriers occur, and determine practical actions to improve outcomes.

Why is collaboration across researchers, providers, industry, policymakers, and patient advocates so important?

The Women's Health Network has grown to more than 170 organizations across research,

healthcare delivery, academic medicine, industry, philanthropy, advocacy, policy, and technology. We intentionally built the network this way, because challenges in women's health can't be solved by a single organization or sector.

Researchers generate evidence, but health systems have to implement it. Industry develops innovative products, but payers have to cover them before women can access them. Our Women, Cancer, and Access Working Group brings together oncologists, health system leaders, researchers, advocacy organizations, and industry experts to develop a framework that's not just evidence-based but implementable in health systems.

What gives you the most hope for the future of women's cancer care?

I started my career as a scientist, so I saw the barriers that prevent innovation from moving from the bench to the bedside. Today we've reached a moment where science, investment, and momentum are beginning to align. We're seeing tremendous advances, but what excites me most is that we've moved beyond simply developing innovations. We're asking how those innovations actually reach women.

Cancer Is Not the Whole Story

Caroline McNally's cancer diagnosis came as a surprise, but so did the outcome. Her story of survival brought her to a place of purpose and perspective.

Eight years ago, I was a 21-year-old student at Penn State University, preparing to become a teacher. I sang in a collegiate cappella group, worked part time at Dunkin' Donuts, and was — as I like to say — overcaffeinated and surrounded by the most fantastic friends and family. Cancer was the last thing on my mind.

When I developed severe abdominal pain, I assumed it was bloating or menstrual cramps. Like many women, I tried to push through it, but the pain became so intense that there were times I couldn't get out of bed. A friend drove me to the emergency room, where I was initially told I had an ectopic pregnancy. I knew that wasn't possible.

At a follow-up appointment, a physician assistant asked how I was coping with my diagnosis. "What diagnosis?" I asked. She replied, "You have ovarian cancer." In that moment, my world changed forever. I had never felt more shocked or disconnected from my own body. At 21, cancer was the last thing I ever expected to hear.

I underwent surgery and chemotherapy for Stage 3 germ cell ovarian cancer. While the physical challenges were overwhelming, the emotional ones lingered long after treatment ended. I continue to navigate body image concerns, anxiety, and, at times, survivor's guilt, despite having no evidence of disease.

The people who impacted me most weren't just my doctors. They were my nurses. They became the faces I saw during every infusion, the people I called when I needed help, my biggest advocates, and more than once, they saved me in ways

I'll never forget. I wanted to be for others what they were for me.

A full-circle outcome

That experience inspired me to leave education behind and become an oncology nurse. Today, I work as a hematology and gynecologic oncology nurse navigator alongside many of the same professionals who once cared for me. I can recognize not only my patients' clinical needs, but also many of the fears and questions that often go unspoken. Caring for the same community that once cared for me is the greatest privilege of my career.

“

A friend drove me to the emergency room, where I was initially told I had an ectopic pregnancy. I knew that wasn't possible.

Recently, I experienced another miracle: becoming a mother. After cancer treatment, I wasn't sure I would ever have children. Thanks to a medical team that preserved my healthy ovary, I welcomed my son into the world. As an adoptee, meeting someone biologically related to me for the first time made that gift even more profound. Every ordinary day, every milestone, and every hug from my son feels like an incredible gift.



Caroline McNally | Photo courtesy of Caroline McNally

Purpose in pain

Motherhood has also given me a new perspective on my cancer journey. When you're the patient, your focus is simply on getting through each day and surviving. Becoming a mother helped me better understand the emotional burden my loved ones carried throughout my treatment.

If you've just been diagnosed with ovarian cancer, know this: Take it one day at a time. Ask questions. Trust your instincts. Advocate for yourself. And through it all, don't

forget to find moments of joy. Laughter won't erase the hard days, but it can help carry you through them.

Cancer is part of my story, but it doesn't define me. I'm a survivor, a nurse, and a mother. I hope my journey reminds others that there can be hope, healing, and purpose beyond an ovarian cancer diagnosis.

Written by **Caroline McNally, B.S.N., RN; Oncology Nurse Navigator, Ovarian Cancer Survivor**

The Role of Genetic Testing in Personalized Ovarian Cancer Care

It began when Lisa felt a random, jarring “pop” in the lower left side of her stomach. It was forceful enough to send her to the emergency room. A computed tomography (CT) scan resulted in an initial diagnosis of diverticulitis, and Lisa spent a week in the hospital.



Lisa | Photo courtesy of Lisa

When she was finally released, she thought the worst was behind her. “That was weird, but it’s over. I’m good to go,” she recalled thinking.

Unfortunately, the relief was short-lived. Months later, the familiar stomach pain returned. Lisa visited a different emergency room, assuming the diverticulitis had flared up again. However, a second CT scan showed that her entire stomach lining was covered in small tumors.

Knowing she needed exceptional care and more information, Lisa quickly contacted the oncology department at her local hospital. Her new care team immediately scheduled PET scans and ran comprehensive blood tests, including a cancer antigen 125 blood test that measures the protein in the blood that is often high in women with ovarian cancer.¹ Because imaging and blood tests alone cannot definitively diagnose ovarian cancer, these findings prompted deeper evaluation (surgical evaluation and biopsy).²

It was through this complete clinical assessment that the true cause of her pain was finally confirmed: Lisa was diagnosed with Stage IV ovarian cancer.

“I didn’t know it at the time, but not only would this be the start of a very challenging time for me, but it would also be the start of my silver lining.”

It’s important to note that the signs and symptoms that Lisa experienced are a part of her own individual journey and are not representative of what other patients may experience.

Her healthcare team, including her medical oncologist and gynecologic oncologist, moved quickly to set a treatment plan. After being treated with chemotherapy, Lisa underwent radical hysterectomy, a surgery to remove the uterus, cervix, and part of the vagina and surrounding tissues, followed by additional chemotherapy.³

Lisa used humor to help her cope with

the difficulty of chemotherapy sessions, bringing electrolytes, a comfortable recliner, and true crime shows to help pass the time.

A shared history

Lisa’s family history prompted her care team to recommend genetic testing to look for inherited mutations.

For Lisa, the results were illuminating. “I had a *BRCA* gene mutation, also called a breast cancer gene mutation,” she shared.⁴ “I didn’t know it at the time, but not only would this be the start of a very challenging time for me, but it would also be the start of my silver lining.”

Having watched her mother navigate cancer and her sister face a *BRCA*-mutated breast cancer diagnosis, Lisa felt empowered by finally having a clear understanding of her own unique disease profile.

Mutations in the *BRCA1* and *BRCA2* genes increase the risk of certain cancers, including breast, ovarian, prostate and pancreatic cancers.⁵ Approximately 13-15% of ovarian cancers are thought to be caused by inherited (germline) *BRCA* mutations, and approximately 5-7% of ovarian cancers are caused by non-inherited (somatic) *BRCA* mutations.⁶

“For people like Lisa who are living with ovarian cancer, understanding a unique genetic profile and specific mutations provides helpful information to guide their care,” explained Roula Qaqish, vice president, head of U.S. Oncology, Medical Affairs, AstraZeneca.¹ “At AstraZeneca, we are committed to following the science of ovarian cancer to drive progress, providing people and their healthcare providers with the targeted options to navigate the path forward together.”

Navigating the next stage

Armed with this knowledge, Lisa and her care team sat down to discuss the next phase of her treatment. While surgery and chemotherapy are often the first steps, some people with advanced ovarian cancer, including Stage IV ovarian cancer, may benefit from continued treatment, known as maintenance therapy, to help reduce the risk of the cancer returning.⁷

Article continues on Page 06

Because Lisa had an inherited *BRCA* mutation, and she had responded well to her initial chemotherapy, her care team recommended a targeted maintenance option.

Together, they had an in-depth conversation about LYNPARZA® (olaparib), a prescription medicine used to treat adults who have advanced ovarian cancer, fallopian tube cancer or primary peritoneal cancer that has a certain type of inherited (germline) or acquired (somatic) abnormal *BRCA* gene mutations.⁸ LYNPARZA is used as maintenance treatment after the cancer has responded to the first treatment with platinum-based chemotherapy.⁸ A healthcare provider will perform a test to make sure that LYNPARZA is right for you.⁸

Before starting treatment, Lisa's care team explained that LYNPARZA is associated with serious, potentially fatal side effects, including bone marrow problems called Myelodysplastic Syndrome (MDS) or Acute Myeloid Leukemia (AML) and lung problems (pneumonitis).⁸ They also discussed the most common side effects of LYNPARZA: anemia, nausea or vomiting, tiredness or weakness, low white blood cell counts, changes in the way food tastes, diarrhea, cough, loss of appetite, dizziness, headache, shortness of breath, indigestion, or heartburn.⁸ These are not all the possible side effects of LYNPARZA. Please see additional Important Safety Information below.

Having thoroughly discussed how the therapy works, its specific uses and the potential side effects, Lisa felt fully informed. She and her care team made the shared decision to move forward with her LYNPARZA maintenance treatment plan.

Lisa has responded to treatment and has experienced side effects, including tiredness, joint pain, and nausea. She has continued with treatment as directed by her doctor. This is Lisa's personal experience, and everyone is different.

"Just having a set plan in place made a big difference for me," Lisa explained. "I am always looking ahead and need to know what we're doing next. Knowing that my disease was being closely monitored was huge. For me, treatment with LYNPARZA wasn't just about maintenance; it was about having a clear treatment plan."

Select safety information regarding LYNPARZA⁸

LYNPARZA has serious risks that may

“ I feel that cancer is a challenge, but it is also a silver lining to me in that it made me value my life more.

lead to death. These include bone marrow problems called myelodysplastic syndrome (MDS) or acute myeloid leukemia (AML), lung problems (pneumonitis), blood clots (venous thromboembolism [VTE]) and liver problems, including drug-induced liver injury (DILI). Signs or symptoms of MDS/AML may include weakness, weight loss, fever, frequent infections, blood in urine or stool, shortness of breath, feeling very tired, or bruising or bleeding more easily. Signs or symptoms of pneumonitis may include new or worsening lung problems, including shortness of breath, fever, cough, or wheezing. Signs or symptoms of VTE may include pain or swelling in an extremity, shortness of breath, chest pain, breathing that is more rapid than normal, or heart beats faster than normal. Signs or symptoms of DILI may include discomfort on the right side of the stomach-area, dark or “tea-colored” urine, or yellowing of the skin or whites of the eyes. Tell your doctor right away if you have any of these signs or symptoms.

This is a summary of some of the most important information you should know about LYNPARZA. For more information about these and other side effects, as well as other information about treatment with LYNPARZA, please see Important Safety Information throughout and on the next page, followed by the Brief Summary of the Full Prescribing Information for LYNPARZA on pages 08 and 09.

Living for today

While continuing maintenance therapy, Lisa remains focused on enjoying time with her stepdaughters and grandchildren, making sure she is fully present for the moments that matter.

"I think all of us tend to walk around thinking we have all the time in the world," she explained. "But when you suddenly are faced with the fact that you might not have that extra time, you stop pushing things off. You stop waiting."

Instead, Lisa focuses on living in the present. "I feel that cancer is a challenge, but it is also a silver lining to me in that it made me value my life more," she noted.



Lisa and her family | Photo courtesy of Lisa

"I spend so much more time doing what I love."

Her advice to others is simple: "Your life is happening now, the days ticking by, with or without your participation. So be bold. Be crazy. Be you."



Visit www.LYNPARZA.com to learn more and talk to your doctor about genetic testing after an ovarian cancer diagnosis.



If you have been prescribed LYNPARZA, the MyLYNPARZA on the Go Support Program provides ongoing support and resources, with the option to receive educational updates and tips directly to your phone via WhatsApp. Visit MyLYNPARZAOnTheGo.com to learn more. The information provided through this program is educational and not a substitute for advice from a healthcare provider. For questions about your treatment, contact your doctor's office.

Editor's Note: Lisa is a LYNPARZA Patient Ambassador and has been compensated by AstraZeneca for sharing her story. Individual patient experiences may vary. Compensation was for time and expenses only and was not contingent

on prescribing, product use, or the content of her statements. Their personal experience may not be typical and does not replace medical advice. Always speak with a qualified healthcare professional about your own care.

Sponsored by AstraZeneca



REFERENCES

1. American Cancer Society. Ovarian cancer early detection, diagnosis, and staging. Accessed July 8, 2026. <https://www.cancer.org/cancer/types/ovarian-cancer/detection-diagnosis-staging.html>.
2. Ovarian Cancer Research Alliance. How is ovarian cancer detected? Accessed July 8, 2026. <https://ocrahope.org/for-patients/gynecologic-cancers/ovarian-cancer/detection-diagnosis/>.
3. National Cancer Institute. NCI dictionary of cancer terms: definition of radical hysterectomy. Accessed July 8, 2026. <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/radical-hysterectomy>.
4. National Breast Cancer Foundation. BRCA: the breast cancer gene. Accessed July 8, 2026. <https://www.nationalbreastcancer.org/what-is-brca/>.
5. Petruccioli N, Daly MB, Pal T. *BRCA1*- and *BRCA2*-associated hereditary breast and ovarian cancer. In: Adam MP, Bick S, Mirzaei GM, et al, eds. *GeneReviews*. Seattle (WA): University of Washington, Seattle; 1998.
6. Andrikopoulou A, Zografos E, Apostolidou K, et al. Germline and somatic variants in ovarian carcinoma: a next-generation sequencing (NGS) analysis. *Front Oncol*. 2022;12:1030786.
7. American Cancer Society. Treating ovarian cancer. Accessed July 8, 2026. <http://cancer.org/cancer/types/ovarian-cancer/treating.html>.
8. LYNPARZA® (olaparib) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2025.

IMPORTANT SAFETY INFORMATION

What is the most important information I should know about LYNPARZA?

LYNPARZA may cause serious side effects, including:

Bone marrow problems called Myelodysplastic Syndrome (MDS) or Acute Myeloid Leukemia (AML).

Some people who have received previous treatment with chemotherapy, radiotherapy, or certain other medicines for their cancer have developed MDS or AML during treatment with LYNPARZA. MDS or AML may lead to death.

Symptoms of low blood cell counts are common during treatment with LYNPARZA, but can be a sign of serious bone marrow problems, including MDS or AML. Symptoms may include weakness, weight loss, fever, frequent infections, blood in urine or stool, shortness of breath, feeling very tired, bruising or bleeding more easily.

Your healthcare provider will do blood tests to check your blood cell counts:

- before treatment with LYNPARZA
- every month during treatment with LYNPARZA
- weekly if you have low blood cell counts that last a long time

Lung problems (pneumonitis).

LYNPARZA can cause serious lung problems that can lead to death. Tell your healthcare provider if you have any new or worsening symptoms of lung problems, including shortness of breath, fever, cough, or wheezing. Your healthcare provider may do a chest x-ray if you have any of these symptoms.

Blood clots (venous thromboembolism [VTE]).

Some people may develop a blood clot in a deep vein, usually in the leg (venous thrombosis) or a clot in the lungs (pulmonary embolism [PE]), which may be severe or lead to death. Tell your healthcare provider right away if you have any symptoms such as pain or swelling in an extremity, shortness of breath, chest pain, breathing that is more rapid than normal (tachypnea), or heart beats faster than normal (tachycardia). Your healthcare provider will monitor you for these symptoms

and may prescribe blood thinner medicine.

Liver problems, including Drug-Induced Liver Injury (DILI): People taking LYNPARZA may develop liver problems which may be severe and can lead to death. Your healthcare provider should do blood tests before and during your treatment with LYNPARZA. Tell your healthcare provider right away if you notice discomfort on the right side of your stomach-area (abdominal), dark or “tea-colored” urine, or yellowing of your skin or the whites of your eyes (jaundice).

Your healthcare provider may change your dose, temporarily stop, or permanently stop treatment with LYNPARZA if you get certain side effects.

Before taking LYNPARZA, tell your healthcare provider about all of your medical conditions, including if you:

- have lung or breathing problems
- have kidney problems
- are pregnant, become pregnant, or plan to become pregnant. LYNPARZA can harm your unborn baby and may cause loss of pregnancy (miscarriage)

Females who are able to become pregnant:

o your healthcare provider may do a pregnancy test before you start treatment with LYNPARZA

o you should use effective birth control (contraception) during treatment with LYNPARZA and for 6 months after the last dose of LYNPARZA. Talk to your healthcare provider about birth control methods that may be right for you

o tell your healthcare provider right away if you become pregnant or think you might be pregnant following treatment with LYNPARZA

- are breastfeeding or plan to breastfeed. It is not known if LYNPARZA passes into your breast milk. Do not breastfeed during treatment with LYNPARZA and for 1 month after receiving the last dose of

LYNPARZA. Talk to your healthcare provider about the best way to feed your baby during this time

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements. Taking LYNPARZA and certain other medicines may affect how LYNPARZA works and may cause side effects.

How should I take LYNPARZA?

- Take LYNPARZA tablets exactly as your healthcare provider tells you
- Your healthcare provider will decide how long you stay on treatment
- Do not change your dose or stop taking LYNPARZA unless your healthcare provider tells you to
- Take LYNPARZA by mouth 2 times a day with or without food
- Each dose should be taken about 12 hours apart
- Swallow LYNPARZA tablets whole. Do not chew, crush, dissolve, or divide the tablets
- If you miss a dose of LYNPARZA, take your next dose at your usual scheduled time. Do not take an extra dose to make up for a missed dose
- If you take too much LYNPARZA, call your healthcare provider or go to the nearest hospital emergency room right away

What should I avoid while taking LYNPARZA?

Avoid grapefruit, grapefruit juice, Seville oranges, and Seville orange juice during treatment with LYNPARZA since they may increase the level of LYNPARZA in your blood.

LYNPARZA may cause serious side effects (see “What is the most important information I should know about LYNPARZA?”).

Nausea or vomiting is common during treatment with LYNPARZA. Tell your healthcare provider if you get nausea or vomiting. Your healthcare provider may prescribe medicines to treat these symptoms.

The most common side effects of LYNPARZA when used alone are:

- tiredness or weakness
- low red blood cell counts
- diarrhea
- loss of appetite
- headache
- changes in the way food tastes
- cough
- low white blood cell counts
- shortness of breath
- dizziness
- indigestion or heartburn
- low platelet counts

These are not all the possible side effects of LYNPARZA. Call your healthcare provider for medical advice about side effects. You are encouraged to report negative side effects of AstraZeneca prescription drugs by calling 1-800-236-9933. If you prefer to report these to the FDA, call 1-800-FDA-1088.

WHAT IS LYNPARZA?

LYNPARZA is a prescription medicine used to treat adults who have ovarian, fallopian tube, or primary peritoneal cancer that is advanced and has a certain type of inherited (germline) or acquired (somatic) abnormal *BRCA* gene. LYNPARZA is used as maintenance treatment after the cancer has responded to your first treatment with platinum-based chemotherapy.

Your healthcare provider will perform a test to make sure that LYNPARZA is right for you.

It is not known if LYNPARZA is safe and effective in children.

LYNPARZA is a registered trademark of the AstraZeneca group of companies.

©2026 AstraZeneca. All rights reserved.

US-114411 8/26

Please see the Brief Summary of the Full Prescribing Information, including the Medication Guide for LYNPARZA, on the next two pages.

IMPORTANT INFORMATION ABOUT LYNPARZA® (Lin-par-zah) (olaparib) TABLETS

What is the most important information I should know about Lynparza?

Lynparza may cause serious side effects, including:

- **Bone marrow problems called Myelodysplastic Syndrome (MDS) or Acute Myeloid Leukemia (AML).** Some people who have received previous treatment with chemotherapy, radiotherapy or certain other medicines for their cancer have developed MDS or AML during treatment with Lynparza. MDS or AML may lead to death. Symptoms of low blood cell counts are common during treatment with Lynparza, but can be a sign of serious bone marrow problems, including MDS or AML. Symptoms may include:

- weakness
- blood in urine or stool
- weight loss
- shortness of breath
- fever
- feeling very tired
- frequent infections
- bruising or bleeding more easily

Your healthcare provider will do blood tests to check your blood cell counts:

- before treatment with Lynparza
- every month during treatment with Lynparza
- weekly if you have low blood cell counts that last a long time.

- **Lung problems (Pneumonitis).** Lynparza can cause serious lung problems that can lead to death. Tell your healthcare provider if you have any new or worsening symptoms of lung problems, including shortness of breath, fever, cough, or wheezing. Your healthcare provider may do a chest x-ray if you have any of these symptoms.
- **Blood clots (Venous Thromboembolism, [VTE]).** Some people may develop a blood clot in a deep vein, usually in the leg (venous thrombosis), or a clot in the lungs (pulmonary embolism, [PE]) which may be severe or lead to death. Tell your healthcare provider right away if you have any symptoms such as pain or swelling in an extremity, shortness of breath, chest pain, breathing that is more rapid than normal (tachypnea), or heart beats faster than normal

(continued)

(tachycardia). Your healthcare provider will monitor you for these symptoms and may prescribe blood thinner medicine.

- **Liver problems, including Drug-Induced Liver Injury (DILI).** People taking Lynparza may develop liver problems which may be severe and can lead to death. Your healthcare provider should do blood tests before and during your treatment with Lynparza. Tell your healthcare provider right away if you notice discomfort on the right side of your stomach-area (abdominal), dark or “tea-colored” urine, or yellowing of your skin or the whites of your eyes (jaundice).

Your healthcare provider may change your dose, temporarily stop, or permanently stop treatment with Lynparza if you get certain side effects.

See “What are the possible side effects of LYNPARZA?” for more information about side effects.

What is Lynparza?

Lynparza is a prescription medicine used to treat adults who have:

- ovarian, fallopian tube, or primary peritoneal cancer:
 - that is advanced and has a certain type of inherited (germline) or acquired (somatic) abnormal *BRCA* gene. Lynparza is used as maintenance treatment after the cancer has responded to your first treatment with platinum-based chemotherapy.
 - in combination with another anti-cancer medicine called bevacizumab when your cancer is advanced and homologous recombination deficiency (HRD) positive, which is identified by a certain type of abnormal *BRCA* gene or a positive laboratory tumor test for genomic instability. Lynparza is used as maintenance treatment after the cancer has responded to your first treatment with platinum-based chemotherapy.
 - that has come back and has a certain type of

(continued)

inherited or acquired abnormal *BRCA* gene. Lynparza is used as maintenance treatment after the cancer has responded to treatment with platinum-based chemotherapy.

Your healthcare provider will perform a test to make sure that Lynparza is right for you.

It is not known if Lynparza is safe and effective in children.

Before taking Lynparza, tell your healthcare provider about all of your medical conditions, including if you:

- have lung or breathing problems
- have kidney problems
- are pregnant, become pregnant, or plan to become pregnant. Lynparza can harm your unborn baby and may cause loss of pregnancy (miscarriage).

Females who are able to become pregnant:

- Your healthcare provider may do a pregnancy test before you start treatment with Lynparza.
- You should use effective birth control (contraception) during treatment with Lynparza and for 6 months after the last dose of Lynparza. Talk to your healthcare provider about birth control methods that may be right for you.
- Tell your healthcare provider right away if you become pregnant or think you might be pregnant following treatment
- are breastfeeding or plan to breastfeed. It is not known if Lynparza passes into your breast milk. Do not breastfeed during treatment with Lynparza and for 1 month after receiving the last dose of Lynparza. Talk to your healthcare provider about the best way to feed your baby during this time.

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements. Taking Lynparza and certain other medicines may affect how Lynparza works and may cause side effects.

(continued)

IMPORTANT INFORMATION ABOUT LYNPARZA® (Lin-par-zah) (olaparib) TABLETS

How should I take Lynparza?

- Take Lynparza tablets exactly as your healthcare provider tells you.
- Your healthcare provider will decide how long you stay on treatment.
- Do not change your dose or stop taking Lynparza unless your healthcare provider tells you to.
- Take Lynparza by mouth 2 times a day, with or without food.
- Each dose should be taken about 12 hours apart.
- Swallow Lynparza tablets whole. Do not chew, crush, dissolve, or divide the tablets.
- If you miss a dose of Lynparza, take your next dose at your usual scheduled time. Do not take an extra dose to make up for a missed dose.
- If you take too much Lynparza, call your healthcare provider or go to the nearest hospital emergency room right away.

What should I avoid while taking Lynparza?

Avoid grapefruit, grapefruit juice, Seville oranges and Seville orange juice during treatment with Lynparza since they may increase the level of Lynparza in your blood.

What are the possible side effects of Lynparza?

Lynparza may cause serious side effects.

- See “What is the most important information I should know about Lynparza?”

The most common side effects of Lynparza when used alone are:

- tiredness or weakness
- cough

(continued)

- low red blood cell counts
- low white blood cell counts
- diarrhea
- shortness of breath
- loss of appetite
- dizziness
- headache
- indigestion or heartburn
- changes in the way food tastes
- low platelet counts

The most common side effects of Lynparza when used in combination with bevacizumab are:

- tiredness or weakness
- low white blood cell counts
- low red blood cell counts
- urinary tract infection
- diarrhea
- headache

Nausea or vomiting is common during treatment with Lynparza. Tell your healthcare provider if you get nausea or vomiting. Your healthcare provider may prescribe medicines to treat these symptoms.

These are not all of the possible side effects of Lynparza.

Call your healthcare provider for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store Lynparza?

- Store Lynparza at room temperature, between 68°F to 77°F (20°C to 25°C).
- Store Lynparza in the original bottle to protect it from moisture.

Keep Lynparza and all medicines out of reach of children.

(continued)

General information about the safe and effective use of Lynparza.

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. Do not use Lynparza for a condition for which it was not prescribed. Do not give Lynparza to other people, even if they have the same symptoms that you have. It may harm them.

You can ask your pharmacist or healthcare provider for information about Lynparza that is written for health professionals

What are the ingredients in Lynparza?

Active ingredient: olaparib

Inactive ingredients:

Tablet contains: copovidone, mannitol, colloidal silicon dioxide and sodium stearyl fumarate

Tablet coating contains: hypromellose, polyethylene glycol 400, titanium dioxide, ferric oxide yellow and ferrousferrous oxide (150 mg tablet only)

Lynparza is a registered trademark of the AstraZeneca group of companies.

©AstraZeneca 2025

Distributed by:
AstraZeneca Pharmaceuticals LP
Wilmington, DE 19850

For more information, call 1-800-236-9933 or go to www.Lynparza.com.

The Keys to Better Research, Prevention, and Treatment of Gynecologic Cancers

Matthew A. Powell, M.D., president of the Society of Gynecologic Oncology, answers key questions about gynecologic cancer awareness, prevention, and advances in care.



INTERVIEW WITH
Matthew A. Powell, M.D.
President, Society of Gynecologic Oncology;
Professor, Division of Gynecologic Oncology,
Washington University School of Medicine in St. Louis

Why is greater public awareness of gynecologic cancers so important?

More than 115,000 women in the United States develop gynecologic cancers each year, yet these cancers are still not talked about enough. Social media has helped raise awareness, but not everyone is on social media, and not everyone grew up in a family or culture where health concerns, particularly those involving the female reproductive tract, were openly discussed.

What symptoms should people pay particular attention to?

Irregular bleeding is a big one, especially after menopause. If you start bleeding again, that's something you should talk to your doctor about. Abnormal bleeding can also happen before menopause. Bleeding between periods or after sexual activity can be a sign that something is wrong. It doesn't always mean cancer, but it should be evaluated.

Other signs include changes in bowel or bladder habits, or symptoms that persist over time. These can be fairly subtle and may be associated with ovarian or fallopian tube cancer. People may think they're experiencing a stomach or bowel problem when, really, something else is going on.

For vulvar and vaginal cancers, watch for abnormal skin changes, growths, lumps, or bumps in the genital area. Don't ignore them. They should be evaluated by a healthcare professional.

Where should someone start if they have concerning or persistent symptoms?

A primary care physician is a good place to start, as is an obstetrician-gynecologist who specializes in women's health. If symptoms persist or the problem can't be resolved, you may need to see a gynecologic oncologist, who has additional specialized training in gynecologic cancers.

What are some of the most important risk factors people should understand?

Each of these cancers has a different

risk profile. For ovarian and fallopian tube cancers, family history can be particularly important. If you have a family history of breast, ovarian, or fallopian tube cancer, that's something you should talk to your doctor about.

With uterine cancer, if you weren't having regular periods throughout most of your life, you could be at increased risk. Diabetes, being overweight, and other hormonal factors can also increase risk.



As a gynecologic oncologist, I often see women who have had symptoms for a long time. They knew something wasn't quite right, but they may not have realized it was something they needed to seek care for.

Cervical cancer risk is closely linked to HPV, and vaccination can prevent most HPV-related cancers, including most cervical cancers. It can also prevent precancerous changes that may otherwise lead to additional testing and biopsies.

What recent advances in prevention or treatment are particularly encouraging?

We've made significant advances in treating metastatic cancer, but ultimately, we want to prevent cancer whenever possible.

We have compelling data showing that removing the fallopian tubes after childbearing can significantly reduce the risk of ovarian cancer. We now understand that many ovarian cancers actually begin in the fallopian tubes. The ovaries can remain in place, so women don't have to

undergo immediate menopause.

What role does the Society of Gynecologic Oncology (SGO) play in advancing care?

SGO brings together more than 2,500 members dedicated to advancing research, improving patient care, and giving healthcare professionals the knowledge they need to provide the highest-quality care possible.

Our members are also leading research and clinical trials that help move the field forward. SGO helps educate physicians on conducting high-quality clinical research and helps patients understand what clinical trials are, why participation may be important, and what to expect. That education can take some of the mystery out of clinical trials and help patients make informed decisions about their care.

Ultimately, our goal is to give patients and their healthcare teams the knowledge they need to prevent these cancers when possible, recognize them earlier, and provide the best care when cancer does occur.



The Mammogram We Can Afford — the Cancer We Can't

Funding is a critical barrier between when and how cancer is treated and who can access care. Instead of relying on outcomes with fast results, the market has a chance to invest in equitable strategies.



WRITTEN BY
Caitlyn Barrett, Ph.D.
Director, Science Philanthropy
Accelerator for Research
and Collaboration (SPARC),
Milken Institute



WRITTEN BY
Hadly Clark, M.H.S.A.
Director,
FasterCures,
Milken Institute



WRITTEN BY
Yun Fu
Associate Director,
Catalytic Capital,
Milken Institute

Cancer prevention and early detection save lives and money, yet their financing remains an afterthought. That failure is especially consequential for women. In 2025, more than 316,000 American women were expected to be diagnosed with breast cancer, which carried the largest economic burden among the major cancers examined in our recent report "Financing Cancer Care: Investing in Prevention, Detection, and Early Diagnosis."

The stakes of catching cancer early are considerable: Roughly 92% of women with breast cancer are alive five years later, but that figure depends heavily on the stage at diagnosis. Women diagnosed while the cancer is localized see survival rates near 100%. Cervical cancer, by contrast, is one of the most preventable and detectable cancers, yet it kills more than 4,000 women annually, disproportionately those without reliable access to screening. The Centers for Disease Control and Prevention's national breast and cervical cancer screening program has reached more than 6.5 million low-income and underinsured women, but it operates on roughly \$200 million a year — a fraction of what the need demands.

Policy costs prevention

One of us is a cancer biologist, drawn to the field after her grandmother survived cancer at a cancer center, only to have a later metastasis missed at a local hospital. The other two of us are breast cancer survivors, both diagnosed in our 30s, before routine screening would typically have started. For us, imaging and biopsy caught cancer early, when treatment was more likely to cure and far less costly. For one of us, it was caught so early that death was never part of the conversation. That is what early detection buys: not just better odds but an entirely different conversation — one about living beyond cancer, not dying from it.

In many cases, these issues are not failures of science. A cancer caught at Stage 1 can cost a fraction of what it costs at Stage 4. For breast cancer specifically, per-case treatment costs rise from tens of thousands of dollars at Stage 1 to costs that are roughly ten times higher by Stage 4, driven by the years of systemic therapy, hospitalization, and palliative care that late-stage disease requires.

Yet the way cancer care is financed continues to favor treatment over prevention. This imbalance reflects a fundamental market failure: The benefits of

screening and early diagnosis are spread across patients, employers, insurers, health systems, and governments, often over many years. The organization that pays for a mammogram today may never capture the savings from avoiding late-stage treatment tomorrow. Capital, therefore, flows more readily toward interventions with immediate revenue streams and outcomes, while prevention and early detection remain underfunded.



The stakes of catching cancer early are considerable:
Roughly 92% of women with breast cancer are alive five years later, but that figure depends heavily on the stage at diagnosis.

Future-forward solutions

Our report identifies financing strategies that could help correct this market failure and ensure that

advances in prevention and early detection reach more women.

- **Syndicated investment funds** could turn insurers and employers into co-investors in diagnostic companies, giving them a financial stake in tools that may ultimately reduce their future costs.
- **Revolving loan funds** could finance mammography equipment and screening infrastructure in rural and underserved communities where access gaps are widest.
- **Cancer bonds** could convert decades of anticipated savings into capital we can deploy now, rather than waiting for the benefits to materialize.
- **Blended finance vehicles** could deploy catalytic capital to de-risk investments in companies developing liquid biopsies and multicancer early detection tests, helping promising innovations cross the gap between the laboratory and the patient.

Reinventing how we pay for cancer prevention and early detection is not a policy footnote. For millions of women, it means finding cancer while the future is still theirs to plan.

What People Need to Know About Bleeding After Menopause

Endometrial cancer is one of the most common and aggressive forms of cancer, leading to late-stage diagnosis. Fortunately, treatments have advanced, and new paradigms in patient care and research are emerging.



“

For the first time in the history of endometrial cancer, **we're starting to see cures in patients we never thought we would.**

We don't talk enough about endometrial cancer. This disease, also known as uterine cancer, is one of the most common gynecologic cancers in America — and both incidences and deaths are on the rise.

There were an estimated 69,000 cases in 2025, with 13,000 deaths resulting from the disease. That number has risen about 1% every year since the mid-2000s, primarily in post-menopausal people with uteruses and especially Black individuals. Endometrial cancer often appears as unexpected vaginal bleeding. It is frequently aggressive and caught at a later stage, which contributes to its deadliness.

Cures are possible

Fortunately, there have also been several major advances in the fight against endometrial cancer in recent years. The focus on molecular mutations (signals within the tumor) has exploded. We understand the biology of the disease much better, allowing us to be more

strategic with our treatment approaches.

There were three pivotal trials recently that looked at the use of immune checkpoint inhibitors (a type of immunotherapy) in tandem with chemotherapy. The results were particularly striking for patients with a molecular marker known as mismatch repair deficiency, or dMMR. That includes about a quarter of all endometrial cancer patients. The studies found that for people with dMMR, the use of immune checkpoint inhibitors more than doubled the cure rate for advanced or recurring cancer.

For the first time in the history of endometrial cancer, we're starting to see cures in patients we never thought we would.

Guidelines that save lives

That's why the National Comprehensive Cancer Network (NCCN) Guidelines® for Uterine Cancer now recommend immunotherapy in addition to chemotherapy regimens as a first line of treatment for people with advanced or

recurring dMMR endometrial cancer. Not only is it potentially more effective — it may also be easier for patients to tolerate. Side effects from immunotherapy can be serious but are rare.

Also, the NCCN Guidelines for Uterine Cancer now recommend that everyone who is diagnosed with endometrial cancer receive multigene panel testing. This helps target the right treatment to the right patient, while also providing an alert for elevated risk of other cancers, both in the patient themselves and for their family members. Patients who are treated for endometrial cancer should double check that they receive multigene panel testing that aligns with the latest recommendations.

Patient-centered resources

Patient education always plays an important role in improving outcomes for any type of cancer. The NCCN Guidelines for Patients® are one example of free, trustworthy, easy-to-understand resources that empower people facing cancer and caregivers with the same

information that care providers rely on worldwide. The patient guideline for uterine cancer was updated this year in both English and Spanish. There are also books updated this year that focus on topics like genetic testing and managing side effects from immune checkpoint inhibitors.

The Society of Gynecologic Oncology and the International Gynecologic Cancer Society are two other organizations that provide meaningful and accurate information on endometrial cancer.

Bottom line: Patients should discuss any information they find with their provider in order to make the best shared decisions for their individual care.



WRITTEN BY
Ritu Salani, M.D., M.B.A.
Gynecologic Oncologist,
UCLA Jonsson Comprehensive
Cancer Center; Member,
NCCN Guidelines® Panel for
Cervical/Uterine Cancers

Let's End the Deadliest Cancer No One Talks About

Lung cancer is the leading cause of cancer death in women, yet it remains misunderstood, underfunded, and stigmatized. It's time to rewrite that narrative.

When someone tells you they have cancer, what's your first reaction? Sympathy? Worry? A silent prayer? If they say it's lung cancer, do you also wonder if they have a smoking history? Lung cancer is the only cancer for which people are still blamed for being sick. That stigma is dangerous and deadly.

Here's the truth: most women diagnosed with lung cancer today are not current smokers. In fact, over 80% are either former smokers or have never smoked a day in their lives. Still, lung cancer remains one of the least funded, least understood, and most overlooked diseases in America, especially when it comes to women. Let's change that.

The deadly cost of stigma

Most people don't realize that lung cancer causes more deaths for women every year than breast and ovarian cancers combined. Yet, we still treat

it like a man's disease or a smoker's disease — or worse, a self-inflicted one.

That's costing women their lives. We now know that lung cancer behaves differently in women than it does in men. It can show up earlier, grow differently, and respond to treatment in unique ways. These sex- and gender-based differences could hold the key to earlier detection, better treatments, and, most importantly, more lives saved.

Furthermore, decades of stigma have resulted in lung cancer receiving the lowest research funding among major cancers impacting women. It's time to end the blame, bridge the gap, and invest in life-saving solutions.

Saving women's lives

This isn't just about science, it's about survival. When a woman is diagnosed with lung cancer, the impact ripples through her family, her job, and her community. Women make 80% of

“ We can change the story. We can fund the research. We can end the stigma. We can save lives. ”

healthcare decisions in this country. They hold 60% of the personal wealth. They drive 85% of consumer spending. When we invest in women's health, everyone benefits.

Being No. 1 isn't always something to be proud of. Lung cancer is the No. 1 cause of cancer death for women, but it doesn't have to be.

We can change the story. We can fund the research. We can end the stigma. We can save lives.

Let's get to work.



WRITTEN BY
Laurie Ambrose
President & CEO
Emeritus, and
Co-Founder, GO2
for Lung Cancer

Many Women Don't Know the Signs of This Common Form of Cancer. That's a Problem.

Real change starts with awareness — and that's especially true for endometrial cancer (EC), which is found in the lining of the uterus and is the most common type of uterine cancer. Despite rising diagnoses and deaths, many women remain unfamiliar with the disease and its warning signs.

In the United States, uterine cancer is the fourth most frequently diagnosed cancer for women, and in 2025, there were more than 69,000 new cases of uterine cancer and nearly 14,000 deaths. Because EC accounts for about 90% of uterine cancer diagnoses, increasing awareness of its symptoms is an important step toward earlier detection and treatment.

To advance that effort, Eisai launched Spot Her® For EC, an initiative that aims to help women understand the signs of EC, and help them feel empowered to speak up and take action at an early stage.

Often, women with EC feel stigmatized or dismissed when they voice their symptoms, while others may assume what

they're experiencing is normal. But early diagnosis is critical, as the disease is more treatable in its initial stages.

Know the signs

Signs of EC may include:

- Abnormal vaginal bleeding or discharge
- Irregular or heavy periods before menopause
- Pain or pressure in the pelvic area
- Losing weight without trying

These are not all the signs, and some symptoms may be overlooked or attributed to other causes. It's important to talk to your doctor promptly about any symptoms that concern you.

Risk factors

Some of the common risk factors of EC may include:

- Obesity and/or a diet high in fat
- Type 2 diabetes
- Age (risk increases with age)
- PCOS (polycystic ovarian syndrome)
- History of hormone therapy
- You or a relative testing positive for Lynch syndrome

Spot Her encourages people to recognize potential signs and risk factors earlier and help normalize conversations about gynecologic health so that women seek medical attention sooner. The initiative was created in collaboration with leading patient



Photo courtesy of Eisai

advocacy organizations and offers educational resources and support throughout the EC journey.

Sponsored by **Eisai**

US6155



To learn more and help end the silence around EC, visit **SpotHerForEC.com**



Erin Andrews: Early Cancer Detection, Advocacy, and Breaking the Silence

FOX Sports broadcaster Erin Andrews is comfortable on camera, but confronting a troubling mammogram screening resurfaced the fear she and many women face when it comes to cancer. Andrews uses her story to fuel her advocacy and honest conversations.

You've been open about your own cancer journey. How has that experience shaped the way you think about women's health today?

I'm really diligent about getting checked now that I've gone through what I went through. I remember going for a mammogram a couple of years ago after a doctor had found something six months earlier and wanted to monitor it. I was a mess for six months. I kept putting the appointment off, because I was terrified of getting bad news.

When I finally went back, I started having a panic attack in the waiting room. I looked at the woman at the desk and said, "I need to get into the room right now. I'm literally going to pass out." The doctor came in, and I just started crying. I told him, "I've been thinking about this for six months. I've been told I have cancer before, and I'm really freaked out."

He said something that really stuck with me: Once you've been told you have cancer, you're always waiting for it again. Every doctor's appointment becomes scary. You don't walk in carefree anymore.

Thankfully, it ended up being nothing, but it completely changes the way you experience healthcare.

What do you wish more women understood about early detection and advocating for themselves in the healthcare system?

Advocating for yourself is everything. I learned that the hard way with my first surgery after my cervical cancer diagnosis. I trusted the doctor



Erin Andrews | Photo courtesy of FOX Sports

who diagnosed me to do the procedure, and honestly, she hacked up my cervix. It was a mess. I should have gone straight to an oncologist. Thankfully, I did that for my second surgery.

You have to ask questions. You have to get information. You can't just assume everything is being handled the best possible way.

Through your platform, you've become a voice for awareness. What responsibility comes with that?

When I first spoke publicly about my diagnosis, I wasn't thinking about responsibility.

I was doing an interview about football and the Super Bowl, and someone simply asked me how my year had been.

I said, "It was wild." I shared that I had been diagnosed with cervical cancer during the season and kept it private. The next morning, it was everywhere. Doctors were on TV talking about how many women are diagnosed with cervical cancer and how important early detection is.

Then I started hearing from people — friends, football coaches, players, owners — thanking me because the women in their lives hadn't been going

to the doctor.

That shocked me. I had been getting checked regularly, and we still found cancer.

What conversations are still missing around gynecologic cancers and women's cancers overall?

What's concerning is that the ages are getting younger. I remember when colonoscopies were recommended at 50, and now they've lowered the age to 45. Mammograms used to feel like something for women in their 40s, and now many doctors are encouraging screenings much earlier.

“

Once you've been told you have cancer, you're always waiting for it again.

Every doctor's appointment becomes scary. You don't walk in carefree anymore.

What would you say to women who are avoiding screenings or putting their health last?

Early detection is key. I was doing routine yearly screenings. I'm very diligent about it. And I was still shocked at how quickly things escalated from one year to the next. Within a year, I went from a routine appointment to discussions about surgeries and a hysterectomy. Things can develop quickly.

Looking ahead, what gives you hope when it comes to cancer care and support for women?

I think people are less embarrassed to talk about cancer now. When my dad was diagnosed with prostate cancer, he didn't want anyone to know. When I was diagnosed, I worked in a male-dominated environment and felt awkward talking about cervical cancer.

But once I started speaking openly about it, I realized everybody has women in their lives they care about — mothers, sisters, wives, daughters, friends. Cancer is cancer. It doesn't matter where it strikes.

Preventing Cervical Cancer: Why Vaccination and Screening Still Matter

While cervical cancer is largely preventable, gaps in vaccination, screening, and access to care remain. Ensuring people have the information and tools they need to protect themselves is critical to improving outcomes.

An estimated 13,490 new cases of invasive cervical cancer will be diagnosed in the United States in 2026, and approximately 4,200 women will die from the disease, according to the American Cancer Society. Although cervical cancer incidence and death rates have declined dramatically over the past several decades, progress has stabilized in recent years.

In public health, we often reference the expression, “An ounce of prevention is worth a pound of cure.” This is an ideal lens through which we can view cervical cancer as a case study.

Prevention and early detection

Human papillomavirus (HPV) vaccination is one of our most powerful tools for cancer prevention. The HPV vaccine can prevent more than 90% of cancers caused by HPV, including cervical and other HPV-associated cancers.

The Centers for Disease Control and Prevention recommends routine HPV vaccination at ages 11 or 12, although vaccination can begin at age 9. Catch-up vaccination is recommended through age 26 for those who were not adequately vaccinated earlier. Some adults ages 27 through 45 may also choose vaccination after discussing their individual circumstances with a healthcare provider.

Beyond vaccination, screening remains critical. Nearly all cervical cancers are caused by persistent infection with certain types of

HPV, and screening can identify HPV infections and precancerous changes before they develop into invasive cancer.

Screening itself is also evolving. Current guidelines increasingly emphasize primary HPV testing, and newer options allow some patients to self-collect a vaginal sample for HPV testing. These options have the potential to make screening more accessible to people who face barriers to traditional cervical screening.

The impact of prevention is already evident: Cervical cancer incidence rates fell by more than half from the mid-1970s to the mid-2000s, largely because of increased screening. More recently, rates among women ages 20 to 24 have declined sharply, likely reflecting the first effects of HPV vaccination.

Yet there is still more work to do to ensure that everyone can benefit from these advances.

Eliminating disease-associated stigma

The association between HPV and sexual activity can hinder vaccination uptake and adherence to screening recommendations. Misperceptions about HPV vaccination and stigma surrounding the virus can make conversations about prevention more difficult.

Increasing uptake will require continuing to destigmatize HPV and helping individuals and families understand HPV vaccination for what it is: an important tool for cancer prevention.



Reframing the conversation

While HPV vaccination is perhaps best known for its role in preventing cervical cancer, HPV can cause several other cancers as well, including vaginal, vulvar, anal, penile, and oropharyngeal cancers. HPV vaccination therefore has implications for cancer prevention across genders.

This is why conversations about HPV vaccination should not be limited to cervical cancer alone. Educational materials and healthcare providers have an important role to play in helping people understand the broader cancer-prevention benefits of vaccination.

Expanding access to prevention

Having effective prevention tools is only meaningful if people can access and use them.

Barriers to preventive healthcare — including inadequate insurance coverage, transportation challenges, geographic inability to access care, and limited ability to take time away from work — can make it more difficult for some people to receive recommended cancer screening and other preventive services.

New approaches to cervical cancer screening could help address some of those barriers. Updated guidance now recognizes self-collected HPV

testing as an option for certain average-risk patients, offering another pathway for people who may otherwise go unscreened.

At the same time, vaccination does not eliminate the need for screening. People who have received the HPV vaccine should still follow recommended cervical cancer screening guidelines.

Closing the gap

We have seen the impact that evidence-based practices like vaccination and screening can have on cervical cancer incidence and mortality. Cervical cancer was once one of the most common causes of cancer death among American women; today, the death rate is less than half what it was in the mid-1970s, largely because of prevention and screening.

But preventable cases and deaths continue to occur. The opportunity now is to make sure the progress in prevention and early detection reaches everyone.

Continuing to normalize conversations about HPV, increasing vaccination, expanding access to screening, and ensuring sufficient research funding across gynecologic cancers can help close remaining gaps and improve outcomes for women and all people at risk for cervical cancer.



WRITTEN BY
Kathryn G. Schubert, MPP, CAE
President and CEO, Society for Women's Health Research (SWHR)



To learn more about Women vs. Cancer,
visit **futureofpersonalhealth.com**

